PEDIATRIC HISTORY FORM (Age 12 and Under)

Dear New Patient,
It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____ S.S. #:_____-_____-_____

Address:_____ City:_____

State:_____ Zip:_____ Home Phone:_____

Birth Date: _____/_____ /_____ Work Phone: _____

Sex:_____ Weight:_____ Height: _____ Referred By:_____

Names of Parents / Guardians: _____

Purpose For Contacting Us? _____ ____

_____

Other Doctors Seen for this Condition: □ No □ Yes Doctors' Names and Prior Treatments: _____

_____

Other Health Problems? _____

Check any of the Following Conditions Your Child has Suffered from During the Past Six Months:

□ Ear Infections	□ Scoliosis	□ Seizures	□ Chronic Colds	□ Headaches
□ Asthma / Allergies	□ Digestive Problems	□ Colic	□ Recurring Fevers	□ ADHD
□ Growing / Back Pains	□ Bed Wetting	□ Car Accident	□ Temper Tantrums	□ Other _____

Family History: _____

Previous Chiropractor: _____

Date of Last Visit: _____ / _____ / _____ Reason: _____

Name of Pediatrician: _____

Date of Last Visit: _____ / _____ / _____ Reason: _____

Are You Satisfied with the Care Your Child has Received There ? □ No □ Yes

# of Doses of Antibiotics Child has Taken In the Past Six Months: _____ , Total During His / Her Lifetime:_____

# of Doses of Other Prescription Medications Your Child has Taken: In the Past Six Months: _____

Total During His / Her Lifetime:_____ List Which: _____

Did You Choose to have Your Child Vaccinated? □ No □ Yes History: _____

Have You Noticed Any Side Effects or Changes Post-Vaccination? _____

PRENATAL HISTORY: Name of Obstetrician/Midwife: _____

Complications During Pregnancy ? □ No □ Yes, List: _____

Ultrasounds During Pregnancy ? □ No □ Yes, Number: _____

Medications During Pregnancy / Delivery ? □ No □ Yes, List: _____

Cigarette / Alcohol Use During Pregnancy: □ No □ Yes

Location of Birth: □ Hospital □ Birthing Center □ Home

Birth Intervention: Forceps Vacuum Extraction Caesarean Section, Emergency or Planned?

Complications During Delivery ? □ No □ Yes, List: _____

Genetic Disorders or Disabilities ? □ No □ Yes, List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

FEEDING HISTORY:

Breast Fed: □ No □ Yes, How Long: _____

Formula Fed: □ No □ Yes, How Long: _____ Type: _____

Introduced Solids @: _____ Months, Cows' Milk @: _____ Months

Food / Juice Allergies or Intolerances: □ No □ Yes, List: _____

_____

DEVELOPMENTAL HISTORY:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spine & nerve interference).

At what age was your child able to:

Respond to Sound _____ Cross Crawl _____ Respond to Visual Stimuli _____

Stand Alone _____ Hold Head Up _____ Walk Alone_____ Sit Up _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.) Was this the case with your child? □ No □ Yes

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, Wrestling, etc.) ? □ No □ Yes, List: _____

_____

Has Your Child Ever Been Involved in a Car Accident ? □ No □ Yes, List: _____

Has Your Child Been Seen on an Emergency Basis? □ No □ Yes, List: _____

Other Traumas Not Described Above ? □ No □ Yes, List: _____

Prior Surgery? □ No □ Yes, List: _____

Menarche: □ No □ Yes, Age: _____

CHILDHOOD DISEASES:

Chicken Pox	N / Y Age: _____	Mumps	N / Y Age: _____
Rubella	N / Y Age: _____	Whooping Cough	N / Y Age: _____
Rubeola	N / Y Age: _____	Other _____	N / Y Age: _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.

YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: _____ Witnessed: _____Date: _____

Name of Insurance Company: _____ Policy #: _____